General Assembly **Amendment**

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Offered by:
SEN. CRISCO, 17th Dist.
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To: Subst. Senate Bill No. **1158** File No. 326 Cal. No. 227

"AN ACT CONCERNING UTILIZATION REVIEW, GRIEVANCES AND EXTERNAL APPEALS PROCESSES OF HEALTH CARRIERS."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. (NEW) (*Effective July 1, 2011*) As used in this section and sections 2 to 13, inclusive, of this act:

(1) "Adverse determination" means:

(A) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's treating health care professional, based on a determination by a health carrier or its designee utilization review company:

(i) That, based upon the information provided, (I) upon application of any utilization review technique, such benefit does not meet the

health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or (II) is determined to be experimental or investigational;

(ii) Of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(B) Any prospective review, concurrent review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's treating health care professional.

"Adverse determination" includes a rescission of coverage determination for grievance purposes.

(2) "Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person for the purposes of this section and sections 2 to 13, inclusive, of this act;

(B) A person authorized by law to provide substituted consent for a covered person;

(C) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;

(D) A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or

(E) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

(3) "Best evidence" means evidence based on (A) randomized clinical trials, (B) if randomized clinical trials are not available, cohort

studies or case-control studies, (C) if such trials and studies are not available, case-series, or (D) if such trials, studies and case-series are not available, expert opinion.

(4) "Case-control study" means a retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

(5) "Case-series" means an evaluation of a series of patients with a particular outcome, without the use of a control group.

(6) "Certification" means a determination by a health carrier or its designee utilization review company that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

(7) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

(8) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.

(9) "Cohort study" means a prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention or specific interventions.

(10) "Commissioner" means the Insurance Commissioner.

(11) "Concurrent review" means utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting, including home care.

(12) "Covered benefits" or "benefits" means health care services to which a covered person is entitled under the terms of a health benefit plan.

(13) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

(14) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent lay-person with an average knowledge of health and medicine, acting reasonably, would have believed that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

(15) "Emergency services" means, with respect to an emergency medical condition:

(A) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

(B) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

(16) "Evidence-based standard" means the conscientious, explicit and judicious use of the current best evidence based on an overall systematic review of medical research when making determinations about the care of individual patients.

(17) "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.

(18) "Facility" means an institution providing health care services or a health care setting. "Facility" includes a hospital and other licensed inpatient center, ambulatory surgical or treatment center, skilled nursing center, residential treatment center, diagnostic, laboratory and imaging center, and rehabilitation and other therapeutic health care setting.

(19) "Final adverse determination" means an adverse determination (A) that has been upheld by the health carrier at the completion of its internal grievance process, or (B) for which the internal grievance process has been deemed exhausted.

(20) "Grievance" means a written complaint or, if the complaint involves an urgent care request, an oral complaint, submitted by or on behalf of a covered person regarding:

(A) The availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(B) Claims payment, handling or reimbursement for health care services; or

(C) Any matter pertaining to the contractual relationship between a covered person and a health carrier.

(21) (A) "Health benefit plan" means an insurance policy or contract, certificate or agreement offered, delivered, issued for delivery, renewed, amended or continued in this state to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services;

(B) "Health benefit plan" does not include:

(i) Coverage of the type specified in subdivisions (5) to (9), inclusive, (14) and (15) of section 38a-469 of the general statutes or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation insurance;

(v) Automobile medical payment insurance;

(vi) Credit insurance;

(vii) Coverage for on-site medical clinics;

(viii) Other insurance coverage similar to the coverages specified in subparagraphs (B)(ii) to (B)(vii), inclusive, of this subdivision that are specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, under which benefits for health care services are secondary or incidental to other insurance benefits;

(ix) (I) Limited scope dental or vision benefits, (II) benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof, or (III) other similar, limited benefits specified in regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended from time to time, provided any benefits specified in subparagraphs (B)(ix)(I) to (B)(ix)(III), inclusive, of this subdivision are provided under a separate insurance policy, certificate or contract and are not otherwise an integral part of a health benefit plan; or

(x) Coverage of the type specified in subdivisions (3) and (13) of section 38a-469 of the general statutes or other fixed indemnity insurance if (I) they are provided under a separate insurance policy, certificate or contract, (II) there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and (III) the benefits are paid with respect to an event without regard to whether benefits were also provided under any group health plan maintained

by the same plan sponsor.

(22) "Health care center" has the same meaning as provided in section 38a-175 of the general statutes.

(23) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(24) "Health care services" has the same meaning as provided in section 38a-478 of the general statutes, as amended by this act.

(25) "Health carrier" means an entity subject to the insurance laws and regulations of this state or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health care center, a managed care organization, a hospital service corporation, a medical service corporation or any other entity providing a plan of health insurance, health benefits or health care services.

(26) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relate to (A) the past, present or future physical, mental, or behavioral health or condition of a covered person or a member of the covered person's family, (B) the provision of health care services to a covered person, or (C) payment for the provision of health care services to a covered person.

(27) "Independent review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations. Such review entities include, but are not limited to, medical peer review organizations, independent utilization review companies, provided such organizations or companies are not related to or associated with any health carrier, and nationally recognized health experts or institutions approved by the Insurance

Commissioner.

(28) "Medical or scientific evidence" means evidence found in the following sources:

(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) or Elsevier Science for indexing in Excerpta Medicus (EMBASE);

(C) Medical journals recognized by the Secretary of the United States Department of Health and Human Services under Section 1861(t)(2) of the Social Security Act;

(D) The following standard reference compendia: (i) The American Hospital Formulary Service - Drug Information; (ii) Drug Facts and Comparisons; (iii) The American Dental Association's Accepted Dental Therapeutics; and (iv) The United States Pharmacopoeia - Drug Information;

(E) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including: (i) The Agency for Healthcare Research and Quality; (ii) the National Institutes of Health; (iii) the National Cancer Institute; (iv) the National Academy of Sciences; (v) the Centers for Medicare and Medicaid Services; (vi) the Food and Drug Administration; and (vii) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services; or

(F) Any other findings, studies or research conducted by or under the auspices of a source comparable to those listed in subparagraphs (E)(i) to (E)(v), inclusive, of this subdivision.

(29) "Medical necessity" has the same meaning as provided in sections 38a-482a and 38a-513c of the general statutes.

(30) "Participating provider" means a health care professional who, under a contract with the health carrier, its contractor or subcontractor, has agreed to provide health care services to covered persons, with an expectation of receiving payment or reimbursement directly or indirectly from the health carrier, other than coinsurance, copayments or deductibles.

(31) "Person" has the same meaning as provided in section 38a-1 of the general statutes.

(32) "Prospective review" means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment, in accordance with a health carrier's requirement that such service or treatment be approved, in whole or in part, prior to such service's or treatment's provision.

(33) "Protected health information" means health information (A) that identifies an individual who is the subject of the information, or (B) for which there is a reasonable basis to believe that such information could be used to identify such individual.

(34) "Randomized clinical trial" means a controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study, with only the experimental group of patients receiving a specific intervention, and that includes study of the groups for variables and anticipated outcomes over time.

(35) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. "Rescission"

does not include a cancellation or discontinuance of coverage under a health benefit plan if (A) such cancellation or discontinuance has a prospective effect only, or (B) such cancellation or discontinuance is effective retroactively to the extent it is attributable to the covered person's failure to timely pay required premiums or contributions towards the cost of such coverage.

(36) "Retrospective review" means any review of a request for a benefit that is not a prospective review or concurrent review. "Retrospective review" does not include a review of a request that is limited to the veracity of documentation or the accuracy of coding.

(37) "Stabilize" means, with respect to an emergency medical condition, that (A) no material deterioration of such condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or (B) with respect to a pregnant woman, the woman has delivered, including the placenta.

(38) "Urgent care request" means a request for a health care service or course of treatment for which the time period for making a non-urgent care request determination (A) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or (B) in the opinion of a health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment being requested.

(39) "Utilization review" means the use of a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy or efficiency of, health care services, health care procedures or health care settings. Such techniques may include the monitoring of or evaluation of (A) health care services performed or provided in an outpatient setting, (B) the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge

from a facility, (C) opportunities or requirements to obtain a clinical evaluation by a health care professional other than the one originally making a recommendation for a proposed health care service, (D) coordinated sets of activities conducted for individual patient management of serious, complicated, protracted or other health conditions, or (E) prospective review, concurrent review, retrospective review or certification.

(40) "Utilization review company" means an entity that conducts utilization review.

Sec. 2. (NEW) (*Effective July 1, 2011*) (a) Sections 1 to 13, inclusive, of this act shall apply to (1) any health carrier offering a health benefit plan and that provides or performs utilization review including prospective, concurrent or retrospective review benefit determinations, and (2) any utilization review company or designee of a health carrier that performs utilization review on the health carrier's behalf, including prospective, concurrent or retrospective review benefit determinations.

(b) Each health carrier shall be responsible for monitoring all utilization review program activities carried out by or on behalf of such health carrier. Such health carrier shall comply with the provisions of sections 1 to 13, inclusive, of this act and any regulations adopted thereunder, and shall be responsible for ensuring that any utilization review company or other entity such health carrier contracts with to perform utilization review complies with said sections and regulations. Each health carrier shall ensure that appropriate personnel have operational responsibility for the activities of the health carrier's utilization review program.

(c) (1) A health carrier that requires utilization review of a benefit request under a health benefit plan shall implement a utilization review program and develop a written document that describes all utilization review activities and procedures, whether or not delegated, for (A) the filing of benefit requests, (B) the notification to covered

persons of utilization review and benefit determinations, and (C) the review of adverse determinations and grievances in accordance with sections 5 and 6 of this act.

(2) Such document shall describe the following:

(A) Procedures to evaluate the medical necessity, appropriateness, health care setting, level of care or effectiveness of health care services;

(B) Data sources and clinical review criteria used in making determinations;

(C) Procedures to ensure consistent application of clinical review criteria and compatible determinations;

(D) Data collection processes and analytical methods used to assess utilization of health care services;

(E) Provisions to ensure the confidentiality of clinical, proprietary and protected health information;

(F) The health carrier's organizational mechanism, such as a utilization review committee or quality assurance or other committee, that periodically assesses the health carrier's utilization review program and reports to the health carrier's governing body; and

(G) The health carrier's staff position that is responsible for the day-to-day management of the utilization review program.

(d) Each health carrier shall:

(1) Include in the insurance policy, certificate of coverage or handbook provided to covered persons a clear and comprehensive description of:

(A) Its utilization review and benefit determination procedures;

(B) Its grievance procedures, including the grievance procedures for requesting a review of an adverse determination;

(C) A description of the external review procedures set forth in section 7 of this act, in a format prescribed by the commissioner and including a statement that discloses that:

(i) A covered person may file a request for an external review of an adverse determination or a final adverse determination with the commissioner and that such review is available when the adverse determination or the final adverse determination involves an issue of medical necessity, appropriateness, health care setting, level of care or effectiveness. Such disclosure shall include the contact information of the commissioner; and

(ii) When filing a request for an external review of an adverse determination or a final adverse determination, the covered person shall be required to authorize the release of any medical records that may be required to be reviewed for the purpose of making a decision on such request;

(D) A statement of the rights and responsibilities of covered persons with respect to each of the procedures under subparagraphs (A) to (C), inclusive, of this subdivision. Such statement shall include a disclosure that a covered person has the right to contact the commissioner's office or the Office of Healthcare Advocate at any time for assistance and shall include the contact information for said offices;

(2) Inform its covered persons, at the time of initial enrollment and at least annually thereafter, of its grievance procedures. This requirement may be fulfilled by including such procedures in an enrollment agreement or update to such agreement;

(3) Inform a covered person and the covered person's health care professional of the health carrier's grievance procedures whenever the health carrier denies certification of a benefit requested by a covered person's health care professional;

(4) Include in materials intended for prospective covered persons a summary of its utilization review and benefit determination

procedures;

(5) Print on its membership or identification cards a toll-free telephone number for utilization review and benefit determinations;

(6) Maintain records of all benefit requests, claims and notices associated with utilization review and benefit determinations made in accordance with section 4 of this act for not less than six years after such requests, claims and notices were made. Each health carrier shall make such records available for examination by the commissioner and appropriate federal oversight agencies upon request; and

(7) Maintain records in accordance with section 8 of this act of all grievances received. Each health carrier shall make such records available for examination by covered persons, to the extent such records are permitted to be disclosed by law, the commissioner and appropriate federal oversight agencies upon request.

(e) (1) On or before March first annually, each health carrier shall file with the commissioner:

(A) A summary report of its utilization review program activities in the calendar year immediately preceding; and

(B) A report that includes for each type of health benefit plan offered by the health carrier:

(i) A certificate of compliance certifying that the utilization review program of the health carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;

(ii) The number of covered lives;

(iii) The total number of grievances received;

(iv) The number of grievances resolved at each level, if applicable, and their resolution;

(v) The number of grievances appealed to the commissioner of which the health carrier has been informed;

(vi) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and

(vii) A synopsis of actions being taken to correct any problems identified.

(2) The commissioner shall adopt regulations, in accordance with chapter 54, to establish the form and content of the reports specified in subdivision (1) of this subsection.

Sec. 3. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall contract with (A) health care professionals to administer such health carrier's utilization review program and oversee utilization review determinations, and (B) with clinical peers to evaluate the clinical appropriateness of an adverse determination.

(2) Each utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically by the health carrier's organizational mechanism specified in subparagraph (F) of subdivision (2) of subsection (c) of section 2 of this act to assure such program's ongoing effectiveness. A health carrier may develop its own clinical review criteria or it may purchase or license clinical review criteria from qualified vendors approved by the commissioner. Each health carrier shall make its clinical review criteria available upon request to authorized government agencies.

(b) Each health carrier shall:

(1) Have procedures in place to ensure that the health care professionals administering such health carrier's utilization review program are applying the clinical review criteria consistently in utilization review determinations;

(2) Have data systems sufficient to support utilization review

program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively;

(3) Provide covered persons and participating providers with access to its utilization review staff through a toll-free telephone number or any other free calling option or by electronic means;

(4) Coordinate the utilization review program with other medical management activity conducted by the health carrier, such as quality assurance, credentialing, contracting with health care professionals, data reporting, grievance procedures, processes for assessing member satisfaction and risk management; and

(5) Routinely assess the effectiveness and efficiency of its utilization review program.

(c) If a health carrier delegates any utilization review activities to a utilization review company, the health carrier shall maintain adequate oversight, which shall include (1) a written description of the utilization review company's activities and responsibilities, including such company's reporting requirements, (2) evidence of the health carrier's formal approval of the utilization review company program, and (3) a process by which the health carrier shall evaluate the utilization review company's performance.

(d) When conducting utilization review, the health carrier shall (1) collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination, and (2) ensure that such review is conducted in a manner to ensure the independence and impartiality of the individual or individuals involved in making the utilization review or benefit determination. No health carrier shall make decisions regarding the hiring, compensation, termination, promotion or other similar matters of such individual or individuals based on the likelihood that the individual or individuals will support the denial of benefits.

Sec. 4. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall

maintain written procedures for (A) utilization review and benefit determinations, (B) expedited utilization review and benefit determinations with respect to prospective urgent care requests and concurrent review urgent care requests, and (C) notifying covered persons or covered persons' authorized representatives of such review and benefit determinations. Each health carrier shall make such review and benefit determinations within the specified time periods under this section.

(2) In determining whether a benefit request shall be considered an urgent care request, an individual acting on behalf of a health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine, except that any benefit request determined to be an urgent care request by a health care professional with knowledge of the covered person's medical condition shall be deemed an urgent care request.

(b) With respect to a nonurgent care request:

(1) For a prospective or concurrent review request, a health carrier shall make a determination within a reasonable period of time appropriate to the covered person's medical condition, but not later than fifteen calendar days after the date the health carrier receives such request, and shall notify the covered person and, if applicable, the covered person's authorized representative of such determination, whether or not the carrier certifies the provision of the benefit.

(2) For a retrospective review request, a health carrier shall make a determination within a reasonable period of time, but not later than thirty calendar days after the date the health carrier receives such request.

(3) The time periods specified in subdivisions (1) and (2) of this subsection may be extended once by the health carrier for up to fifteen calendar days, provided the health carrier:

(A) Determines that an extension is necessary due to circumstances

beyond the health carrier's control; and

(B) Notifies the covered person and, if applicable, the covered person's authorized representative prior to the expiration of the initial time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

(4) (A) If the extension pursuant to subdivision (3) of this subsection is necessary due to the failure of the covered person or the covered person's authorized representative to provide information necessary to make a determination on the request, the health carrier shall:

(i) Specifically describe in the notice of extension the required information necessary to complete the request; and

(ii) Provide the covered person and, if applicable, the covered person's authorized representative with not less than forty-five calendar days after the date of receipt of the notice to provide the specified information.

(B) If the covered person or the covered person's authorized representative fails to submit the specified information before the end of the period of the extension, the health carrier may deny certification of the benefit requested.

(c) With respect to an urgent care request:

(1) Unless the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, the health carrier shall make a determination as soon as possible, taking into account the covered person's medical condition, but not later than seventy-two hours after the health carrier receives such request, provided, if the urgent care request is a concurrent review request to extend a course of treatment beyond the initial period of time or the number of treatments, such request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments;

(2) (A) If the covered person or the covered person's authorized representative has failed to provide information necessary for the health carrier to make a determination, the health carrier shall notify the covered person or the covered person's representative, as applicable, as soon as possible, but not later than twenty-four hours after the health carrier receives such request.

(B) The health carrier shall provide the covered person or the covered person's authorized representative, as applicable, a reasonable period of time to submit the specified information, taking into account the covered person's medical condition, but not less than forty-eight hours after notifying the covered person or the covered person's authorized representative, as applicable.

(3) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of its determination as soon as possible, but not later than forty-eight hours after the earlier of (i) the date on which the covered person and the covered person's authorized representative, as applicable, provides the specified information to the health carrier, or (ii) the date on which the specified information was to have been submitted.

(d) (1) Whenever a health carrier receives a review request from a covered person or a covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of such failure not later than five calendar days after the health carrier receives such request, except that for an urgent care request, the health carrier shall notify the covered person and, if applicable, the covered person's authorized representative of such failure not later than twenty-four hours after the health carrier receives such request.

(2) If the health carrier provides such notice orally, the health carrier shall provide confirmation in writing to the covered person and the covered person's health care professional of record not later than five

calendar days after providing the oral notice.

(e) Each health carrier shall provide promptly to a covered person and, if applicable, the covered person's authorized representative a notice of an adverse determination. Such notice may be provided in writing or by electronic means and shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

(1) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount;

(2) The specific reason or reasons for the adverse determination and a description of the health carrier's standard, if any, that was used in reaching the denial;

(3) Reference to the specific health benefit plan provisions on which the determination is based;

(4) A description of any additional material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim;

(5) A description of the health carrier's internal grievance process that includes (A) the health carrier's expedited review procedures, (B) any time limits applicable to such process or procedures, (C) the contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and (D) a statement that the covered person or, if applicable, the covered person's authorized representative is entitled, pursuant to the requirements of the health carrier's internal grievance process, to (i) submit written comments, documents, records and other material relating to the covered person's benefit request for consideration by the individual or individuals conducting the review, and (ii) receive from the health carrier, free of charge upon request, reasonable access to and

copies of all documents, records and other information relevant to the covered person's benefit request;

(6) If the adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (A) the specific rule, guideline, protocol or other similar criterion, or (B) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request, and instructions for requesting such copy;

(7) If the adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the adverse determination and (A) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances, or (B) a statement that an explanation will be provided to the covered person free of charge upon request, and instructions for requesting a copy of such explanation; and

(8) A statement explaining the right of the covered person to contact the commissioner's office or the Office of the Healthcare Advocate at any time for assistance or, upon completion of the health carrier's internal grievance process, to file a civil suit in a court of competent jurisdiction. Such statement shall include the contact information for said offices.

(f) If the adverse determination is a rescission, the health carrier shall include with the advance notice of the application for rescission required to be sent to the covered person, a written statement that includes:

(1) Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;

(2) An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;

(3) A disclosure that the covered person or the covered person's authorized representative may file immediately, without waiting for the date such advance notice of the proposed rescission ends, a grievance with the health carrier to request a review of the adverse determination to rescind coverage, pursuant to sections 5 and 6 of this act;

(4) A description of the health carrier's grievance procedures established under sections 5 and 6 of this act, including any time limits applicable to those procedures; and

(5) The date such advance notice of the proposed rescission ends and the date back to which the coverage will be retroactively rescinded.

(g) (1) Whenever a health carrier fails to strictly adhere to the requirements of this section with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review in accordance with the provisions of section 7 of this act, regardless of whether the health carrier asserts it substantially complied with the requirements of this section or that any error it committed was de minimis.

(2) A covered person who has exhausted the internal grievance process of a health carrier may, in addition to filing a request for an external review, pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal grievance process that would yield a decision on the merits of the claim.

Sec. 5. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall establish and maintain written procedures for (A) the review of

grievances of adverse determinations that were based, in whole or in part, on medical necessity, (B) the expedited review of grievances of adverse determinations of urgent care requests, including concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility, and (C) notifying covered persons or covered persons' authorized representatives of such adverse determinations.

(2) Each health carrier shall file with the commissioner a copy of such procedures, including all forms used to process requests, and any subsequent material modifications to such procedures.

(3) In addition to a copy of such procedures, each health carrier shall file annually with the commissioner, as part of its annual report required under subsection (e) of section 2 of this act, a certificate of compliance stating that the health carrier has established and maintains grievance procedures for each of its health benefit plans that are fully compliant with the provisions of sections 1 to 13, inclusive, of this act.

(b) (1) A covered person or a covered person's authorized representative may file a grievance of an adverse determination that was based, in whole or in part, on medical necessity with the health carrier not later than one hundred eighty calendar days after the covered person or the covered person's authorized representative, as applicable, receives the notice of an adverse determination.

(2) For prospective or concurrent urgent care requests, a covered person or a covered person's authorized representative may make a request for an expedited review orally or in writing.

(c) (1) (A) When conducting a review of an adverse determination under this section, the health carrier shall ensure that such review is conducted in a manner to ensure the independence and impartiality of the individual or individuals involved in making the review decision.

(B) If the adverse determination involves utilization review, the health carrier shall designate an appropriate clinical peer or peers to review such adverse determination. Such clinical peer or peers shall not have been involved in the initial adverse determination.

(C) The individual or individuals conducting a review under this section shall take into consideration all comments, documents, records and other information relevant to the covered person's benefit request that is the subject of the adverse determination under review, that are submitted by the covered person or the covered person's authorized representative, regardless of whether such information was submitted or considered in making the initial adverse determination.

(D) Prior to issuing a decision, the health carrier shall provide free of charge to the covered person or the covered person's authorized representative, as applicable, any new or additional evidence relied upon and any new or additional scientific or clinical rationale used by the health carrier in connection with the grievance. Such evidence and rationale shall be provided sufficiently in advance of the date the health carrier is required to issue a decision to permit the covered person or the covered person's authorized representative, as applicable, a reasonable opportunity to respond prior to such date.

(2) If the review under subdivision (1) of this subsection is an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the covered person's authorized representative, as applicable, by telephone, facsimile, electronic means or any other expeditious method available.

(3) If the review under subdivision (1) of this subsection is an expedited review of a grievance involving an adverse determination of a concurrent review urgent care request, the treatment shall be continued without liability to the covered person until the covered person has been notified of the review decision.

(d) (1) The health carrier shall notify the covered person and, if

applicable, the covered person's authorized representative, in writing or by electronic means, of its decision within a reasonable period of time appropriate to the covered person's medical condition, but not later than:

(A) For prospective review and concurrent review requests, thirty calendar days after the health carrier receives the grievance;

(B) For retrospective review requests, sixty calendar days after the health carrier receives the grievance; and

(C) For expedited review requests, seventy-two hours after the health carrier receives the grievance.

(2) The time periods set forth in subdivision (1) of this subsection shall apply regardless of whether all of the information necessary to make a decision accompanies the filing.

(e) The notice required under subsection (d) of this section shall set forth, in a manner calculated to be understood by the covered person or the covered person's authorized representative:

(1) The titles and qualifying credentials of the individual or individuals participating in the review process;

(2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, if applicable, the health care professional and the claim amount;

(3) A statement of such individual's or individuals' understanding of the covered person's grievance;

(4) The individual's or individuals' decision in clear terms and the health benefit plan contract basis or scientific or clinical rationale for such decision in sufficient detail for the covered person to respond further to the health carrier's position;

(5) Reference to the evidence or documentation used as the basis for

the decision;

(6) For a decision that upholds the adverse determination:

(A) The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(B) Reference to the specific health benefit plan provisions on which the decision is based;

(C) A statement that the covered person may receive from the health carrier, free of charge and upon request, reasonable access to and copies of, all documents, records and other information relevant to the adverse determination under review;

(D) If the final adverse determination is based on a health carrier's internal rule, guideline, protocol or other similar criterion, (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that a specific rule, guideline, protocol or other similar criterion of the health carrier was relied upon to make the final adverse determination and that a copy of such rule, guideline, protocol or other similar criterion will be provided to the covered person free of charge upon request and instructions for requesting such copy;

(E) If the final adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the final adverse determination and (i) an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the covered person's medical circumstances, or (ii) a statement that an explanation will be provided to the covered person free of charge upon request and instructions for requesting a copy of such explanation;

(F) A statement describing the procedures for obtaining an external

review of the final adverse determination;

(7) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

(8) A statement disclosing the covered person's right to contact the commissioner's office or the Office of the Healthcare Advocate at any time. Such disclosure shall include the contact information for said offices.

(f) (1) Whenever a health carrier fails to strictly adhere to the requirements of this section with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the internal grievance process of such health carrier and may file a request for an external review, regardless of whether the health carrier asserts that it substantially complied with the requirements of this section, or that any error it committed was de minimis.

(2) A covered person who has exhausted the internal grievance process of a health carrier may, in addition to filing a request for an external review, pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal grievance process that would yield a decision on the merits of the claim.

Sec. 6. (NEW) (*Effective July 1, 2011*) (a) Each health carrier shall establish and maintain written procedures (1) for the review of grievances of adverse determinations that were not based on medical necessity, and (2) notifying covered persons or covered persons' authorized representatives of such adverse determinations.

(b) (1) A covered person or the covered person's authorized representative may file a grievance of an adverse determination that was not based on medical necessity with the health carrier not later

than one hundred eighty calendar days after the covered person or the covered person's representative, as applicable, receives the notice of an adverse determination.

(2) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative not later than three business days after the health carrier receives a grievance that the covered person or the covered person's authorized representative, as applicable, is entitled to submit written material to the health carrier to be considered when conducting a review of the grievance.

(3) (A) Upon receipt of a grievance, a health carrier shall designate an individual or individuals to conduct a review of the grievance.

(B) The health carrier shall not designate the same individual or individuals who denied the claim or handled the matter that is the subject of the grievance to conduct the review of the grievance.

(C) The health carrier shall provide the covered person and, if applicable, the covered person's authorized representative with the name, address and telephone number of the individual or the organizational unit designated to coordinate the review on behalf of the health carrier.

(c) (1) The health carrier shall notify the covered person and, if applicable, the covered person's authorized representative in writing, of its decision not later than twenty business days after the health carrier received the grievance.

(2) If the health carrier is unable to comply with the time period specified in subdivision (1) of this subsection due to circumstances beyond the health carrier's control, the time period may be extended by the health carrier for up to ten business days, provided that on or before the twentieth business day after the health carrier received the grievance, the health carrier provides written notice to the covered person and, if applicable, the covered person's authorized

representative of the extension and the reasons for the delay.

(d) The written decision issued pursuant to subsection (c) of this section shall contain:

(1) The titles and qualifying credentials of the individual or individuals participating in the review process;

(2) A statement of such individual's or individuals' understanding of the covered person's grievance;

(3) The individual's or individuals' decision in clear terms and the health benefit plan contract basis for such decision in sufficient detail for the covered person to respond further to the health carrier's position; and

(4) Reference to the evidence or documentation used as the basis for the decision.

Sec. 7. (NEW) (*Effective July 1, 2011*) (a) (1) A covered person or a covered person's authorized representative may file a request for an external review or an expedited external review of an adverse determination or a final adverse determination in accordance with the provisions of this section. All requests for external review or expedited external review shall be made in writing to the commissioner. The commissioner may prescribe the form and content of such requests.

(2) (A) All requests for external review or expedited external review shall be accompanied by a filing fee of twenty-five dollars, except that no covered person or covered person's authorized representative shall pay more than seventy-five dollars in a calendar year for such covered person. Any filing fee paid by a covered person's authorized representative shall be deemed to have been paid by the covered person. If the commissioner finds that the covered person is indigent or unable to pay the filing fee, the commissioner shall waive such fee. Any such fees shall be deposited in the Insurance Fund established under section 38a-52a of the general statutes.

(B) The commissioner shall refund any paid filing fee to the covered person or the covered person's authorized representative, as applicable, or the health care professional if the adverse determination or the final adverse determination that is the subject of the external review request or expedited external review request is reversed or revised.

(3) The health carrier that issued the adverse determination or the final adverse determination that is the subject of the external review request or the expedited external review request shall pay the independent review organization for the cost of conducting the review.

(4) An external review decision, whether such review is a standard external review or an expedited external review, shall be binding on the health carrier or a self-insured governmental plan and the covered person, except to the extent such health carrier or covered person has other remedies available under federal or state law. A covered person or a covered person's authorized representative shall not file a subsequent request for an external review or an expedited external review that involves the same adverse determination or final adverse determination for which the covered person or the covered person's authorized representative already received an external review decision or an expedited external review decision.

(5) Each health carrier shall maintain written records of external reviews as set forth in section 8 of this act.

(6) Each independent review organization shall maintain written records as set forth in subsection (e) of section 13 of this act.

(b) (1) Except as otherwise provided under subdivision (2) of this subsection or subsection (d) of this section, a covered person or a covered person's authorized representative shall not file a request for an external review or an expedited external review until the covered person or the covered person's authorized representative has exhausted the health carrier's internal grievance process.

(2) A health carrier may waive its internal grievance process and the requirement for a covered person to exhaust such process prior to filing a request for an external review or an expedited external review.

(c) (1) At the same time a health carrier sends to a covered person or a covered person's authorized representative a written notice of an adverse determination or a final adverse determination issued by the health carrier, the health carrier shall include a written disclosure to the covered person and, if applicable, the covered person's authorized representative of the covered person's right to request an external review.

(2) The written notice shall include:

(A) The following statement or a statement in substantially similar language: "We have denied your request for benefit approval for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us by submitting a request for external review to the office of the Insurance Commissioner, if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested.";

(B) For a notice related to an adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition for which the time period for completion of an expedited internal review of a grievance involving an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may (I) file a request for an expedited external review, or (II) file a request for an expedited external review if the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or

investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; and

(ii) Such request for expedited external review may be filed at the same time the covered person or the covered person's authorized representative files a request for an expedited internal review of a grievance involving an adverse determination, except that the independent review organization assigned to conduct the expedited external review shall determine whether the covered person shall be required to complete the expedited internal review of the grievance prior to conducting the expedited external review;

(C) For a notice related to a final adverse determination, a statement informing the covered person that:

(i) If the covered person has a medical condition for which the time period for completion of an external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or the covered person's authorized representative may file a request for an expedited external review; or

(ii) If the final adverse determination concerns (I) an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, the covered person or the covered person's authorized representative may file a request for an expedited external review, or (II) a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or the covered person's authorized representative may file a request for an expedited

external review;

(D) (i) A copy of the description of both the standard and expedited external review procedures the health carrier is required to provide, highlighting the provisions in the external review procedures that give the covered person or the covered person's authorized representative the opportunity to submit additional information and including any forms used to process an external review or an expedited external review;

(ii) As part of any forms provided under subparagraph (D)(i) of this subdivision, an authorization form or other document approved by the commissioner that complies with the requirements of 45 CFR 164.508, as amended from time to time, by which the covered person shall authorize the health carrier and the covered person's treating health care professional to release, transfer or otherwise divulge, in accordance with sections 38a-975 to 38a-999a, inclusive, of the general statutes, the covered person's protected health information including medical records for purposes of conducting an external review or an expedited external review.

(d) (1) A covered person or a covered person's authorized representative may file a request for an expedited external review of an adverse determination or a final adverse determination with the commissioner, except that an expedited external review shall not be provided for a retrospective review request of an adverse determination or a final adverse determination.

(2) Such request may be filed at the time the covered person receives:

(A) An adverse determination, if:

(i) (I) The covered person has a medical condition for which the time period for completion of an expedited internal review of the adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to

regain maximum function; or

(II) The denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; and

(ii) The covered person or the covered person's authorized representative has filed a request for an expedited internal review of the adverse determination; or

(B) A final adverse determination if:

(i) The covered person has a medical condition where the time period for completion of a standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function;

(ii) The final adverse determination concerns an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility; or

(iii) The denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

(3) Such covered person or covered person's authorized representative shall not be required to file a request for an external review prior to, or at the same time as, the filing of a request for an expedited external review and shall not be precluded from filing a request for an external review, within the time periods set forth in

subsection (e) of this section, if the request for an expedited external review is determined to be ineligible for such review.

(e) (1) Not later than one hundred twenty calendar days after a covered person or a covered person's authorized representative receives a notice of an adverse determination or a final adverse determination, the covered person or the covered person's authorized representative may file a request for an external review or an expedited external review with the commissioner in accordance with this section.

(2) Not later than one business day after the commissioner receives a request that is complete, the commissioner shall send a copy of such request to the health carrier that issued the adverse determination or the final adverse determination that is the subject of the request.

(3) Not later than (A) five business days after the health carrier receives the copy of an external review request, or (B) one calendar day after the health carrier receives the copy of an expedited external review request, from the commissioner, the health carrier shall complete a preliminary review of the request to determine whether:

(A) The individual is or was a covered person under the health benefit plan at the time the health care service was requested or, in the case of an external review of a retrospective review request, was a covered person in the health benefit plan at the time the health care service was provided;

(B) The health care service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan but for the health carrier's determination that the health care service is not covered because it does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;

(C) If the health care service or treatment is experimental or

investigational:

(i) Is a covered benefit under the covered person's health benefit plan but for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition;

(ii) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan;

(iii) The covered person's treating health care professional has certified that one of the following situations is applicable:

(I) Standard health care services or treatments have not been effective in improving the medical condition of the covered person;

(II) Standard health care services or treatments are not medically appropriate for the covered person; or

(III) There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the recommended or requested health care service or treatment; and

(iv) The covered person's treating health care professional:

(I) Has recommended a health care service or treatment that the health care professional certifies, in writing, is likely to be more beneficial to the covered person, in the health care professional's opinion, than any available standard health care services or treatments; or

(II) Is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat the covered person's condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the covered person that is the subject of the adverse determination or the final adverse determination is likely to be more beneficial to the covered person than

any available standard health care services or treatments;

(D) The covered person has exhausted the health carrier's internal grievance process or the covered person or the covered person's authorized representative has filed a request for an expedited external review as provided under subsection (d) of this section; and

(E) The covered person has provided all the information and forms required to process an external review or an expedited external review, including an authorization form as set forth in subparagraph (D)(ii) of subdivision (2) of subsection (c) of this section.

(4) (A) Not later than (i) one business day after the preliminary review of an external review request, or (ii) the day the preliminary review of an expedited external review request is completed, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing whether the request for an external review or an expedited external review is complete and eligible for such review. The commissioner may specify the form for the health carrier's notice of initial determination under this subdivision and any supporting information required to be included in the notice.

(B) If the request:

(i) Is not complete, the health carrier shall notify the commissioner and the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice what information or materials are needed to perfect the request; or

(ii) Is not eligible for external review or expedited external review, the health carrier shall notify the commissioner, the covered person and, if applicable, the covered person's authorized representative in writing and include in the notice the reasons for its ineligibility.

(C) The notice of initial determination shall include a statement informing the covered person and, if applicable, the covered person's

authorized representative that a health carrier's initial determination that the request for an external review or an expedited external review is ineligible for review may be appealed to the commissioner.

(D) Notwithstanding a health carrier's initial determination that a request for an external review or an expedited external review is ineligible for review, the commissioner may determine, pursuant to the terms of the covered person's health benefit plan, that such request is eligible for such review and assign an independent review organization to conduct such review. Any such review shall be conducted in accordance with this section.

(f) (1) Whenever the commissioner is notified pursuant to subparagraph (A) of subdivision (4) of subsection (e) of this section that a request is eligible for external review or expedited external review, the commissioner shall, not later than (A) one business day after receiving such notice for an external review, or (B) one calendar day after receiving such notice for an expedited external review:

(i) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to section 12 of this act to conduct the review and notify the health carrier of the name of the assigned independent review organization. Such assignment shall be done on a random basis among those approved independent review organizations qualified to conduct the particular review based on the nature of the health care service that is the subject of the adverse determination or the final adverse determination and other circumstances, including conflict of interest concerns as set forth in section 13 of this act; and

(ii) Notify the covered person and, if applicable, the covered person's authorized representative in writing of the request's eligibility and acceptance for external review or expedited external review. For an external review, the commissioner shall include in such notice (I) a statement that the covered person or the covered person's authorized

representative may submit, not later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, additional information in writing to the assigned independent review organization that such organization shall consider when conducting the external review, and (II) where and how such additional information is to be submitted. If additional information is submitted later than five business days after the covered person or the covered person's authorized representative, as applicable, received such notice, the independent review organization may, but shall not be required to, accept and consider such additional information.

(2) Not later than (A) five business days for an external review, or (B) one calendar day for an expedited external review, after the health carrier receives notice of the name of the assigned independent review organization from the commissioner, the health carrier or its designee utilization review company shall provide to the assigned independent review organization the documents and any information such health carrier or utilization review company considered in making the adverse determination or the final adverse determination.

(3) The failure of the health carrier or its designee utilization review company to provide the documents and information within the time specified in subdivision (2) of this subsection shall not delay the conducting of the review.

(4) (i) If the health carrier or its designee utilization review company fails to provide the documents and information within the time period specified in subdivision (2) of this subsection, the independent review organization may terminate the review and make a decision to reverse the adverse determination or the final adverse determination.

(ii) Not later than one business day after terminating the review and making the decision to reverse the adverse determination or the final adverse determination, the independent review organization shall notify the commissioner, the health carrier, the covered person and, if

applicable, the covered person's authorized representative in writing of such decision.

(g) (1) The assigned independent review organization shall review all the information and documents received pursuant to subsection (f) of this section. In reaching a decision, the independent review organization shall not be bound by any decisions or conclusions reached during the health carrier's utilization review process.

(2) Not later than one business day after receiving any information submitted by the covered person or the covered person's authorized representative pursuant to subparagraph (B) of subdivision (1) of subsection (f) of this section, the independent review organization shall forward such information to the health carrier.

(3) (A) Upon the receipt of any information forwarded pursuant to subdivision (2) of this subsection, the health carrier may reconsider its adverse determination or the final adverse determination that is the subject of the review. Such reconsideration shall not delay or terminate the review.

(B) The independent review organization shall terminate the review if the health carrier decides, upon completion of its reconsideration and notice to such organization as provided in subparagraph (C) of this subdivision, to reverse its adverse determination or its final adverse determination and provide coverage or payment for the health care service or treatment that is the subject of the adverse determination or the final adverse determination.

(C) Not later than one business day after making the decision to reverse its adverse determination or its final adverse determination, the health carrier shall notify the commissioner, the assigned independent review organization, the covered person and, if applicable, the covered person's authorized representative in writing of such decision.

(h) In addition to the documents and information received pursuant

to subsection (f) of this section, the independent review organization shall consider, to the extent the documents or information are available and the independent review organization considers them appropriate, the following in reaching a decision:

(1) The covered person's medical records;

(2) The attending health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other documents submitted by the health carrier, the covered person, the covered person's authorized representative or the covered person's treating health care professional;

(4) The terms of coverage under the covered person's health benefit plan to ensure that the independent review organization's decision is not contrary to the terms of coverage under such health benefit plan;

(5) The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, medical boards or medical associations;

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee utilization review company; and

(7) The opinion or opinions of the independent review organization's clinical peer or peers who conducted the review after considering subdivisions (1) to (6), inclusive, of this subsection.

(i) (1) The independent review organization shall notify the commissioner, the health carrier, the covered person and, if applicable, the covered person's authorized representative in writing of its decision to uphold, reverse or revise the adverse determination or the final adverse determination, not later than:

(A) For external reviews, forty-five calendar days after such organization receives the assignment from the commissioner to

conduct such review;

(B) For external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, twenty calendar days after such organization receives the assignment from the commissioner to conduct such review;

(C) For expedited external reviews, as expeditiously as the covered person's medical condition requires, but not later than seventy-two hours after such organization receives the assignment from the commissioner to conduct such review; and

(D) For expedited external reviews involving a determination that the recommended or requested health care service or treatment is experimental or investigational, as expeditiously as the covered person's medical condition requires, but not later than five calendar days after such organization receives the assignment from the commissioner to conduct such review.

(2) Such notice shall include:

(A) A general description of the reason for the request for the review;

(B) The date the independent review organization received the assignment from the commissioner to conduct the review;

(C) The date the review was conducted;

(D) The date the organization made its decision;

(E) The principal reason or reasons for its decision, including what applicable evidence-based standards, if any, were used as a basis for its decision;

(F) The rationale for the organization's decision;

(G) Reference to the evidence or documentation, including any

evidence-based standards, considered by the organization in reaching its decision; and

(H) For a review involving a determination that the recommended or requested health care service or treatment is experimental or investigational:

(i) A description of the covered person's medical condition;

(ii) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that (I) the recommended or requested health care service or treatment is likely to be more beneficial to the covered person than any available standard health care services or treatments, and (II) the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;

(iii) A description and analysis of any medical or scientific evidence considered in reaching the opinion;

(iv) A description and analysis of any evidence-based standard; and

(v) Information on whether the clinical peer's rationale for the opinion is based on the documents and information set forth in subsection (f) of this section.

(3) Upon the receipt of a notice of the independent review organization's decision to reverse or revise an adverse determination or a final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or the final adverse determination.

Sec. 8. (NEW) (*Effective July 1, 2011*) (a) (1) Each health carrier shall maintain written records to document all grievances of adverse determinations it receives, including the notices and claims associated with such grievances, during a calendar year.

(2) (A) Each health carrier shall maintain such records for not less than six years after the notice of an adverse determination that is the subject of a grievance was provided to a covered person or the covered person's authorized representative, as applicable, under section 4 of this act.

(B) The health carrier shall make such records available for examination by covered persons, to the extent such records are permitted to be disclosed by law, the commissioner and appropriate federal oversight agencies upon request. Such records shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

(b) For each grievance the record shall contain, at a minimum, the following information: (1) A general description of the reason for the grievance; (2) the date the health carrier received the grievance; (3) the date of each review or, if applicable, review meeting of the grievance; (4) the resolution at each level of the grievance, if applicable; (5) the date of resolution at each such level, if applicable; and (6) the name of the covered person for whom the grievance was filed.

(c) Each health carrier shall submit a report annually to the commissioner, in accordance with section 2 of this act, of the grievances it received.

(d) (1) Each health carrier shall maintain written records of all requests for external reviews, whether such requests are for standard or expedited external reviews, that such health carrier receives notice of from the commissioner in a calendar year. The health carrier shall maintain such records in the aggregate by state where the covered person requesting such review resides and by each type of health benefit plan offered by the health carrier, and shall submit a report to the commissioner upon request, in a format prescribed by the commissioner.

(2) Such report shall include, in the aggregate by state where the covered person requesting such review resides and by each type of

health benefit plan:

(A) The total number of requests for an external review, whether such requests were for a standard or expedited external review;

(B) From the total number of such requests reported under subparagraph (A) of this subdivision, the number of requests determined eligible for a full external review, whether such requests were for a standard or expedited external review; and

(C) Any other information the commissioner may request or require.

(3) The health carrier shall retain the written records required pursuant to subdivision (1) of this subsection for not less than six years after the request for an external review or an expedited external review was received.

Sec. 9. (NEW) (*Effective July 1, 2011*) The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of sections 1 to 8, inclusive, of this act.

Sec. 10. (NEW) (*Effective July 1, 2011*) (a) No utilization review company shall conduct utilization review in this state for a health benefit plan under the jurisdiction of the commissioner unless it is licensed by the commissioner. All licenses shall be renewed on an annual basis.

(b) The annual license fee shall be three thousand dollars and shall be dedicated to the regulation of utilization review, except that the commissioner shall be authorized to use such funds as is necessary to (1) implement the provisions of sections 38a-91aa to 38a-91qq, inclusive, of the general statutes, and (2) contract with The University of Connecticut School of Medicine to provide any medical consultations necessary to carry out the commissioner's responsibilities under this title with respect to consumer and market conduct matters.

(c) The request for licensure or renewal shall include the name,

address, telephone number and normal business hours of the utilization review company, the name and telephone number of a person for the commissioner to contact. Any material changes in the information filed in accordance with this subsection shall be filed with the commissioner not later than thirty calendar days after the change.

(d) The commissioner shall receive and investigate all grievances filed against utilization review companies by a covered person. The commissioner shall code, track and review all grievances. The commissioner may impose such penalties as authorized, in accordance with section 11 of this act.

(e) In the absence of any contractual agreement to the contrary, the covered person or the covered person's authorized representative shall be responsible for requesting certification and for authorizing the covered person's treating health care professional to release, in a timely manner, all information necessary to conduct the review. A utilization review company shall permit the covered person, the covered person's authorized representative or the covered person's treating health care professional to assist in fulfilling that responsibility.

Sec. 11. (NEW) (*Effective July 1, 2011*) (a) Whenever the commissioner has reason to believe that a utilization review company subject to sections 1 to 10, inclusive, of this act has been or is engaging in conduct in violation of said sections, and that a proceeding by the commissioner would be in the interest of the public, the commissioner shall issue and serve upon such company a statement of the charges in that respect and a notice of a hearing to be held at a time and place fixed in the notice, which shall not be less than thirty calendar days after the date of service. At the time and place fixed for such hearing, such company shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring such company to cease and desist from the alleged conduct complained of.

(b) If, after such hearing, the commissioner determines that the

utilization review company charged has engaged in a violation of section 4 of this act, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the utilization review company a copy of such findings and an order requiring such company to cease and desist from engaging in such violation. The commissioner may order any of the following:

(1) Payment of a civil penalty of not more than one thousand five hundred dollars for each act or violation, provided such penalty shall not exceed an aggregate penalty of fifteen thousand dollars unless the company knew or reasonably should have known it was in violation of section 4 of this act, in which case the penalty shall be not more than seven thousand five hundred dollars for each act or violation, not to exceed an aggregate penalty of seventy-five thousand dollars in any six-month period;

(2) Suspension or revocation of the utilization review company's license to do business in this state if it knew or reasonably should have known that it was in violation of section 4 of this act; or

(3) Payment of such reasonable expenses as may be necessary to compensate the commissioner in connection with the proceedings under this subsection, which shall be dedicated exclusively to the regulation of utilization review.

(c) Any company aggrieved by any such order of the commissioner may appeal therefrom in accordance with the provisions of section 4-183 of the general statutes, except venue for such appeal shall be in the judicial district of New Britain.

(d) Any person who violates a cease and desist order of the commissioner made pursuant to this section and while such order is in effect shall, after notice and hearing and upon order of the commissioner, be subject to the following: (1) A civil penalty of not more than seventy-five thousand dollars; or (2) suspension or revocation of such person's license.

Sec. 12. (NEW) (*Effective July 1, 2011*) (a) (1) The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews and expedited external reviews under section 7 of this act.

(2) The commissioner shall (A) develop an application form for the initial approval and for the reapproval of independent review organizations, and (B) maintain and periodically update a list of approved independent review organizations.

(b) (1) Any independent review organization seeking to conduct external reviews and expedited external reviews under section 7 of this act shall submit the application form for approval or reapproval, as applicable, to the commissioner and shall include all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under this section.

(2) An approval or reapproval shall be effective for two years, unless the commissioner determines before the expiration of such approval or reapproval that the independent review organization no longer satisfies the minimum qualifications established under this section.

(3) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under this section, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of approved independent review organizations specified in subdivision (2) of subsection (a) of this section.

(c) To be eligible for approval by the commissioner, an independent review organization shall:

(1) Have and maintain written policies and procedures that govern all aspects of both the standard external review process and the

expedited external review process set forth in section 7 of this act that include, at a minimum:

(A) A quality assurance mechanism in place that ensures:

(i) That external reviews and expedited external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(ii) (I) The selection of qualified and impartial clinical peers to conduct such reviews on behalf of the independent review organization and the suitable matching of such peers to specific cases, and (II) employs or contracts with an adequate number of clinical peers to meet this objective;

(iii) The confidentiality of medical and treatment records and clinical review criteria;

(iv) That any person employed by or under contract with the independent review organization adheres to the requirements of section 7 of this act; and

(B) A toll-free telephone number to receive information twenty-four hours a day, seven days a week, related to external reviews and expedited external reviews and that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours;

(2) Agree to maintain and provide to the commissioner the information set forth in section 13 of this act;

(3) Not own or control, be a subsidiary of, be owned or controlled in any way by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of health care professionals; and

(4) Assign as a clinical peer a health care professional who meets the following minimum qualifications:

(A) Is an expert in the treatment of the covered person's medical condition that is the subject of the review;

(B) Is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(C) Holds a nonrestricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review; and

(D) Has no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit or regulatory body that raise a substantial question as to the clinical peer's physical, mental or professional competence or moral character.

(d) (1) An independent review organization that is accredited by a nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed to be in compliance with this section.

(2) The commissioner shall initially review and periodically review the independent review organization accreditation standards of a nationally recognized private accrediting entity to determine whether such entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the National Association of Insurance Commissioners for the purpose of the determination under this subdivision.

(3) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the National Association of

Insurance Commissioners in order for the commissioner to determine if such entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the National Association of Insurance Commissioners.

Sec. 13. (NEW) (*Effective July 1, 2011*) (a) The commissioner shall not assign an independent review organization, and no independent review organization shall assign a clinical peer, to conduct an external review or an expedited external review of a specified case if such organization or clinical peer has a material professional, familial or financial conflict of interest with any of the following:

(1) The health carrier that is the subject of such review;

(2) The covered person whose treatment is the subject of such review or the covered person's authorized representative;

(3) Any officer, director or management employee of the health carrier that is the subject of such review;

(4) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of such review;

(5) The facility at which the recommended health care service or treatment would be provided; or

(6) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of such review.

(b) To determine whether an independent review organization or a clinical peer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of subsection (a) of this section, the commissioner shall consider situations in which the independent review organization to be assigned to conduct an external review or an expedited external

review of a specified case or a clinical peer to be assigned by the independent review organization to conduct such review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in subsection (a) of this section, but the characteristics of such relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical peer from conducting such review.

(c) An independent review organization shall be unbiased. In addition to any other written procedures required under section 12 of this act, an independent review organization shall establish and maintain written procedures to ensure that it is unbiased.

(d) No independent review organization or clinical peer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties during or upon completion of an external review or an expedited external review conducted pursuant to section 7 of this act, unless such opinion was rendered or act or omission performed in bad faith or involved gross negligence.

(e) (1) Each independent review organization assigned by the commissioner to conduct a review pursuant to section 7 of this act shall maintain written records of all external reviews, whether standard or expedited external reviews, conducted by such organization in a calendar year. Such organization shall maintain such records in the aggregate by state where the covered person requesting such review resides and by health carrier, and shall submit a report to the commissioner upon request, in a format prescribed by the commissioner.

(2) Such report shall include, in the aggregate by state where the covered person requesting such review resides and by health carrier:

(A) The total number of requests for an external review, whether such requests were for a standard or an expedited external review;

(B) The number of such requests resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(C) The average length of time for resolution;

(D) A summary of the types of coverages or cases for which a review was sought;

(E) The number of such reviews that were terminated as a result of reconsideration by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(F) Any other information the commissioner may request or require.

(3) Each independent review organization shall retain the written records required pursuant to subdivision (1) of this subsection for not less than six years after the assignment of an external review or an expedited external review.

(f) The commissioner shall adopt regulations, in accordance with chapter 54, to carry out the provisions of this section and sections 10 to 12, inclusive, of this act.

Sec. 14. Section 38a-478 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

As used in this section, sections **[**38a-478**]** 38a-478a to 38a-478o, inclusive, as amended by this act, and subsection (a) of section 38a-478s, as amended by this act:

[(1) "Adverse determination" means a determination by a managed

care organization, health insurer or utilization review company that an admission, service, procedure or extension of stay that is a covered benefit has been reviewed and, based upon the information provided, does not meet the managed care organization's, health insurer's or utilization review company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and such requested admission, service, procedure or extension of stay, or payment for such admission, service, procedure or extension of stay has been denied, reduced or terminated.**]**

[(2)**]** (1) "Commissioner" means the Insurance Commissioner.

[(3)**]** (2) "Covered benefit" or "benefit" means a health care service to which an enrollee is entitled under the terms of a health benefit plan.

[(4)**]** (3) **[**Except as provided in sections 38a-478m and 38a-478n, "enrollee"**]** "Enrollee" means a person who has contracted for or who participates in a managed care plan for such person or such person's eligible dependents.

[(5)**]** (4) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

[(6)**]** (5) "Managed care organization" means an insurer, health care center, hospital or medical service corporation or other organization delivering, issuing for delivery, renewing, amending or continuing any individual or group health managed care plan in this state.

[(7)**]** (6) "Managed care plan" means a product offered by a managed care organization that provides for the financing or delivery of health care services to persons enrolled in the plan through: (A) Arrangements with selected providers to furnish health care services; (B) explicit standards for the selection of participating providers; (C) financial incentives for enrollees to use the participating providers and procedures provided for by the plan; or (D) arrangements that share risks with providers, provided the organization offering a plan

described under subparagraph (A), (B), (C) or (D) of this subdivision is licensed by the Insurance Department pursuant to chapter 698, 698a or 700 and the plan includes utilization review, **[**pursuant to sections 38a-226 to 38a-226d, inclusive**]** as defined in section 1 of this act.

[(8)**]** (7) "Preferred provider network" has the same meaning as provided in section 38a-479aa, as amended by this act.

[(9)**]** (8) "Provider" or "health care provider" means a person licensed to provide health care services under chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

[(10) "Review entity" means an entity that conducts independent external reviews of adverse determinations. Such review entities include, but are not limited to, medical peer review organizations, independent utilization review companies, provided such organizations or companies are not related to or associated with any managed care organization or health insurer, and nationally recognized health experts or institutions approved by the Insurance Commissioner.**]**

[(11)**]** (9) "Utilization review" has the same meaning as provided in section **[**38a-226**]** 1 of this act.

[(12)**]** (10) "Utilization review company" has the same meaning as provided in section **[**38a-226**]** 1 of this act.

Sec. 15. Subsection (c) of section 38a-19 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) The provisions of this section shall not apply to an order or decision of the commissioner made pursuant to section **[**38a-477b or 38a-478n**]** 7 of this act.

Sec. 16. Subsection (b) of section 38a-477b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) An insurer or health care center shall apply for approval of such rescission, cancellation or limitation by submitting such written information to the Insurance Commissioner on an application in such form as the commissioner prescribes. Such insurer or health care center shall provide a copy of the application for such approval to the insured or the insured's representative. Not later than seven business days after receipt of the application for such approval, the insured or the insured's representative shall have an opportunity to review such application and respond and submit relevant information to the commissioner with respect to such application. Not later than fifteen business days after the submission of information by the insured or the insured's representative, the commissioner shall issue a written decision on such application. The commissioner **[**may**]** shall only approve: **[**such rescission, cancellation**]**

(1) Such rescission or limitation if the commissioner finds that **[**(1)**]** (A) the insured or such insured's representative submitted the written information **[**submitted**]** on or with the insurance application that was **[**false**]** fraudulent at the time such application was made, **[**and**]** (B) the insured or such insured's representative **[**knew or should have known of the falsity**]** intentionally misrepresented information therein **[**,**]** and such **[**submission**]** misrepresentation materially affects the risk or the hazard assumed by the insurer or health care center, or **[**(2)**]** (C) the information omitted from the insurance application was **[**knowingly**]** intentionally omitted by the insured or such insured's representative **[**, or the insured or such insured's representative should have known of such omission,**]** and such omission materially affects the risk or the hazard assumed by the insurer or health care center. Such decision shall be mailed to the insured, the insured's representative, if any, and the insurer or health care center; and

(2) Such cancellation in accordance with the provisions set forth in the Public Health Service Act, 42 USC 300gg et seq., as amended from time to time.

Sec. 17. Section 38a-478a of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2011*):

On March **[**1, 1999, and**]** first annually, **[**thereafter,**]** the Insurance Commissioner shall submit a report **[**,**]** to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to public health and **[**relating to**]** insurance, concerning the commissioner's responsibilities under the provisions of sections **[**38a-226 to 38a-226d, inclusive**]** 1 to 8, inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as amended by this act, and 38a-993. The report shall include: (1) A summary of the quality assurance plans submitted by managed care organizations pursuant to section 38a-478c along with suggested changes to improve such plans; (2) suggested modifications to the consumer report card developed under the provisions of section 38a-478*l*; (3) a summary of the commissioner's procedures and activities in conducting market conduct examinations of utilization review companies and preferred provider networks, including, but not limited to: (A) The number of desk and field audits completed during the previous calendar year; (B) a summary of findings of the desk and field audits, including any recommendations made for improvements or modifications; (C) a description of complaints concerning managed care companies, and any preferred provider network that provides services to enrollees on behalf of the managed care organization, including a summary and analysis of any trends or similarities found in the managed care complaints filed by enrollees; (4) a summary of the complaints concerning managed care organizations received by the Insurance Department's Consumer Affairs Division and the commissioner under section **[**38a-478n**]** 7 of this act, including a summary and analysis of any trends or similarities found in the complaints received; (5) a summary of any violations the commissioner has found against any managed care organization or any preferred provider network that provides services to enrollees on behalf of the managed care organization; and (6) a summary of the issues discussed related to health care or managed care organizations at the Insurance Department's quarterly forums throughout the state.

Sec. 18. Section 38a-478b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Each managed care organization, as defined in section 38a-478, that fails to file the data, reports or information required by sections **[**38a-226 to 38a-226d**]** 1 to 8, inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as amended by this act, and 38a-993 shall pay a late fee of one hundred dollars per day for each day from the due date of such data, reports or information to the date of filing. Each managed care organization that files incomplete data, reports or information shall be so informed by the commissioner, shall be given a date by which to remedy such incomplete filing and shall pay said late fee commencing from the new due date.

(b) On June **[**1, 1998, and**]** first annually, **[**thereafter,**]** the commissioner shall submit **[**,**]** to the Governor and to the joint standing committees of the General Assembly having cognizance of matters relating to public health and **[**matters relating to**]** insurance, a list of those managed care organizations that have failed to file any data, report or information required by sections **[**38a-226 to 38a-226d**]** 1 to 8, inclusive, of this act, 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as amended by this act, and 38a-993.

Sec. 19. Section 38a-478h of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Each contract delivered, issued for delivery, renewed, amended or continued in this state **[**on and after October 1, 1997,**]** between a managed care organization and a participating provider shall require the provider to give at least sixty days' advance written notice to the managed care organization and shall require the managed care organization to give at least sixty days' advance written notice to the provider in order to withdraw from or terminate the agreement.

(b) The provisions of this section shall not apply: (1) When lack of such notice is necessary for the health or safety of the enrollees; (2) when a provider has entered into a contract with a managed care

organization that is found to be based on fraud or material misrepresentation; or (3) when a provider engages in any fraudulent activity related to the terms of his contract with the managed care organization.

(c) No managed care organization shall take or threaten to take any action against any provider in retaliation for such provider's assistance to an enrollee under the provisions of **[**subsection (e) of section 38a-226c or section 38a-478n**]** section 7 of this act.

Sec. 20. Subsection (d) of section 38a-478r of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(d) The Insurance Commissioner **[**, after consultation with the working group convened pursuant to section 38a-478p,**]** may develop and disseminate to hospitals in this state a claims form system that will ensure that all hospitals consistently code for the presenting and diagnosis symptoms on all emergency claims.

Sec. 21. Section 38a-478s of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Nothing in sections 38a-478 to 38a-478o, inclusive, as amended by this act, or sections 1 to 8, inclusive, of this act shall be construed to apply to the arrangements of managed care organizations or health insurers offered to individuals covered under self-insured employee welfare benefit plans established pursuant to the federal Employee Retirement Income Security Act of 1974.

(b) The provisions of sections 38a-478 to 38a-478o, inclusive, as amended by this act, and sections 1 to 8, inclusive, of this act shall not apply to any plan that provides for the financing or delivery of health care services solely for the purposes of workers' compensation benefits pursuant to chapter 568.

Sec. 22. Section 38a-478t of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2011*):

The Commissioner of Public Health may request and shall receive any data, report or information filed with the Insurance Commissioner pursuant to the provisions of sections **[**38a-226 to 38a-226d, inclusive**]** 10 and 11 of this act, 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as amended by this act, and 38a-993.

Sec. 23. Section 38a-478u of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

The Insurance Commissioner may adopt regulations in accordance with the provisions of chapter 54 to implement the provisions of sections **[**38a-226 to 38a-226d, inclusive,**]** 38a-478 to 38a-478u, inclusive, as amended by this act, 38a-479aa, as amended by this act, and 38a-993.

Sec. 24. Section 38a-479aa of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) As used in this part and subsection (b) of section 20-138b:

(1) "Covered benefits" means health care services to which an enrollee is entitled under the terms of a managed care plan;

(2) "Enrollee" means an individual who is eligible to receive health care services through a preferred provider network;

(3) "Health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization, and includes hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(4) "Managed care organization" means (A) a managed care organization, as defined in section 38a-478, as amended by this act, (B) any other health insurer, or (C) a reinsurer with respect to health insurance;

(5) "Managed care plan" means a managed care plan, as defined in section 38a-478, as amended by this act;

(6) "Person" means an individual, agency, political subdivision, partnership, corporation, limited liability company, association or any other entity;

(7) "Preferred provider network" means a person, which is not a managed care organization, but which pays claims for the delivery of health care services, accepts financial risk for the delivery of health care services and establishes, operates or maintains an arrangement or contract with providers relating to (A) the health care services rendered by the providers, and (B) the amounts to be paid to the providers for such services. "Preferred provider network" does not include (i) a workers' compensation preferred provider organization established pursuant to section 31-279-10 of the regulations of Connecticut state agencies, (ii) an independent practice association or physician hospital organization whose primary function is to contract with insurers and provide services to providers, (iii) a clinical laboratory, licensed pursuant to section 19a-30, whose primary payments for any contracted or referred services are made to other licensed clinical laboratories or for associated pathology services, or (iv) a pharmacy benefits manager responsible for administering pharmacy claims whose primary function is to administer the pharmacy benefit on behalf of a health benefit plan;

(8) "Provider" means an individual or entity duly licensed or legally authorized to provide health care services; and

(9) "Commissioner" means the Insurance Commissioner.

(b) On and after May 1, 2004, no preferred provider network may enter into or renew a contractual relationship with a managed care organization unless the preferred provider network is licensed by the commissioner. On and after May 1, 2005, no preferred provider network may conduct business in this state unless it is licensed by the commissioner. Any person seeking to obtain or renew a license shall

submit an application to the commissioner, on such form as the commissioner may prescribe, and shall include the filing described in this subsection, except that a person seeking to renew a license may submit only the information necessary to update its previous filing. Applications shall be submitted by March first of each year in order to qualify for the May first license issue or renewal date. The filing required from such preferred provider network shall include the following information: (1) The identity of the preferred provider network and any company or organization controlling the operation of the preferred provider network, including the name, business address, contact person, a description of the controlling company or organization and, where applicable, the following: (A) A certificate from the Secretary of the State regarding the preferred provider network's and the controlling company's or organization's good standing to do business in the state; (B) a copy of the preferred provider network's and the controlling company's or organization's financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, for the end of its most recently concluded fiscal year, along with the name and address of any public accounting firm or internal accountant which prepared or assisted in the preparation of such financial statement; (C) a list of the names, official positions and occupations of members of the preferred provider network's and the controlling company's or organization's board of directors or other policy-making body and of those executive officers who are responsible for the preferred provider network's and controlling company's or organization's activities with respect to the health care services network; (D) a list of the preferred provider network's and the controlling company's or organization's principal owners; (E) in the case of an out-of-state preferred provider network, controlling company or organization, a certificate that such preferred provider network, company or organization is in good standing in its state of organization; (F) in the case of a Connecticut or out-of-state preferred provider network, controlling company or organization, a report of the details of any suspension, sanction or other disciplinary action relating to such preferred provider network, or controlling company or

organization in this state or in any other state; and (G) the identity, address and current relationship of any related or predecessor controlling company or organization. For purposes of this subparagraph, "related" means that a substantial number of the board or policy-making body members, executive officers or principal owners of both companies are the same; (2) a general description of the preferred provider network and participation in the preferred provider network, including: (A) The geographical service area of and the names of the hospitals included in the preferred provider network; (B) the primary care physicians, the specialty physicians, any other contracting providers and the number and percentage of each group's capacity to accept new patients; (C) a list of all entities on whose behalf the preferred provider network has contracts or agreements to provide health care services; (D) a table listing all major categories of health care services provided by the preferred provider network; (E) an approximate number of total enrollees served in all of the preferred provider network's contracts or agreements; (F) a list of subcontractors of the preferred provider network, not including individual participating providers, that assume financial risk from the preferred provider network and to what extent each subcontractor assumes financial risk; (G) a contingency plan describing how contracted health care services will be provided in the event of insolvency; and (H) any other information requested by the commissioner; and (3) the name and address of the person to whom applications may be made for participation.

(c) Any person developing a preferred provider network, or expanding a preferred provider network into a new county, pursuant to this section and subsection (b) of section 20-138b, shall publish a notice, in at least one newspaper having a substantial circulation in the service area in which the preferred provider network operates or will operate, indicating such planned development or expansion. Such notice shall include the medical specialties included in the preferred provider network, the name and address of the person to whom applications may be made for participation and a time frame for

making application. The preferred provider network shall provide the applicant with written acknowledgment of receipt of the application. Each complete application shall be considered by the preferred provider network in a timely manner.

(d) (1) Each preferred provider network shall file with the commissioner and make available upon request from a provider the general criteria for its selection or termination of providers. Disclosure shall not be required of criteria deemed by the preferred provider network to be of a proprietary or competitive nature that would hurt the preferred provider network's ability to compete or to manage health care services. For purposes of this section, criteria is of a proprietary or competitive nature if it has the tendency to cause providers to alter their practice pattern in a manner that would circumvent efforts to contain health care costs and criteria is of a proprietary nature if revealing the criteria would cause the preferred provider network's competitors to obtain valuable business information.

(2) If a preferred provider network uses criteria that have not been filed pursuant to subdivision (1) of this subsection to judge the quality and cost-effectiveness of a provider's practice under any specific program within the preferred provider network, the preferred provider network may not reject or terminate the provider participating in that program based upon such criteria until the provider has been informed of the criteria that the provider's practice fails to meet.

(e) Each preferred provider network shall permit the Insurance Commissioner to inspect its books and records.

(f) Each preferred provider network shall permit the commissioner to examine, under oath, any officer or agent of the preferred provider network or controlling company or organization with respect to the use of the funds of the preferred provider network, company or organization, and compliance with (1) the provisions of this part, and

(2) the terms and conditions of its contracts to provide health care services.

(g) Each preferred provider network shall file with the commissioner a notice of any material modification of any matter or document furnished pursuant to this part, and shall include such supporting documents as are necessary to explain the modification.

(h) Each preferred provider network shall maintain a minimum net worth of either (1) the greater of (A) two hundred fifty thousand dollars, or (B) an amount equal to eight per cent of its annual expenditures as reported on its most recent financial statement completed and filed with the commissioner in accordance with sections 38a-53 and 38a-54, as applicable, or (2) another amount determined by the commissioner.

(i) Each preferred provider network shall maintain or arrange for a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner for the exclusive use of paying any outstanding amounts owed participating providers in the event of insolvency or nonpayment except that any remaining security may be used for the purpose of reimbursing managed care organizations in accordance with subsection (b) of section 38a-479bb. Such outstanding amount shall be at least an amount equal to the greater of (1) an amount sufficient to make payments to participating providers for two months determined on the basis of the two months within the past year with the greatest amounts owed by the preferred provider network to participating providers, (2) the actual outstanding amount owed by the preferred provider network to participating providers, or (3) another amount determined by the commissioner. Such amount may be credited against the preferred provider network's minimum net worth requirements set forth in subsection (h) of this section. The commissioner shall review such security amount and calculation on a quarterly basis.

(j) Each preferred provider network shall pay the applicable license

or renewal fee specified in section 38a-11. The commissioner shall use the amount of such fees solely for the purpose of regulating preferred provider networks.

(k) In no event, including, but not limited to, nonpayment by the managed care organization, insolvency of the managed care organization, or breach of contract between the managed care organization and the preferred provider network, shall a preferred provider network bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against an enrollee or an enrollee's designee, other than the managed care organization, for covered benefits provided, except that the preferred provider network may collect any copayments, deductibles or other out-of-pocket expenses that the enrollee is required to pay pursuant to the managed care plan.

(l) Each contract or agreement between a preferred provider network and a participating provider shall contain a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

(m) Each utilization review determination made by or on behalf of a preferred provider network shall be made in accordance with **[**sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of a determination not to certify an admission, service, procedure or extension of stay shall be conducted in accordance with subdivision (7) of subsection (a) of section 38a-226c, and any subsequent appeal shall be referred to the managed care organization on whose behalf the preferred provider network provides services. The managed care organization shall conduct the subsequent appeal in accordance with said subdivision**]** section 4 of this act.

(n) The requirements of subsections (h) and (i) of this section shall not apply to a consortium of federally qualified health centers funded by the state, providing services only to recipients of programs administered by the Department of Social Services. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to establish criteria to certify any such federally qualified health center, including, but not limited to, minimum reserve fund requirements.

Sec. 25. Subsection (d) of section 38a-479bb of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(d) Each managed care organization shall ensure that any contract it has with a preferred provider network includes:

(1) A provision that requires the preferred provider network to provide to the managed care organization at the time a contract is entered into, annually, and upon request of the managed care organization, (A) the financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, and section 38a-479aa, as amended by this act; (B) documentation that satisfies the managed care organization that the preferred provider network has sufficient ability to accept financial risk; (C) documentation that satisfies the managed care organization that the preferred provider network has appropriate management expertise and infrastructure; (D) documentation that satisfies the managed care organization that the preferred provider network has an adequate provider network taking into account the geographic distribution of enrollees and participating providers and whether participating providers are accepting new patients; (E) an accurate list of participating providers; and (F) documentation that satisfies the managed care organization that the preferred provider network has the ability to ensure the delivery of health care services as set forth in the contract;

(2) A provision that requires the preferred provider network to

provide to the managed care organization a quarterly status report that includes (A) information updating the financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, and section 38a-479aa, as amended by this act; (B) a report showing amounts paid to those providers who provide health care services on behalf of the managed care organization; (C) an estimate of payments due providers but not yet reported by providers; (D) amounts owed to providers for that quarter; and (E) the number of utilization review determinations not to certify an admission, service, procedure or extension of stay made by or on behalf of the preferred provider network and the outcome of such determination on appeal;

(3) A provision that requires the preferred provider network to provide notice to the managed care organization not later than five business days after (A) any change involving the ownership structure of the preferred provider network; (B) financial or operational concerns arise regarding the financial viability of the preferred provider network; or (C) the preferred provider network's loss of a license in this or any other state;

(4) A provision that if the managed care organization fails to pay for health care services as set forth in the contract, the enrollee will not be liable to the provider or preferred provider network for any sums owed by the managed care organization or preferred provider network;

(5) A provision that the preferred provider network shall include in all contracts between the preferred provider network and participating providers a provision that if the preferred provider network fails to pay for health care services as set forth in the contract, for any reason, the enrollee shall not be liable to the participating provider or preferred provider network for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred

provider network;

(6) A provision requiring the preferred provider network to provide information to the managed care organization, satisfactory to the managed care organization, regarding the preferred provider network's reserves for financial risk;

(7) A provision that (A) the preferred provider network or managed care organization shall post and maintain a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner, in order to satisfy the risk accepted by the preferred provider network pursuant to the contract, in an amount calculated in accordance with subsection (i) of section 38a-479aa, as amended by this act, (B) the managed care organization shall determine who posts and maintains the security required under subparagraph (A) of this subdivision, and (C) in the event of insolvency or nonpayment, such security shall be used by the preferred provider network, or other entity designated by the commissioner, solely for the purpose of paying any outstanding amounts owed participating providers, except that any remaining security may be used for the purpose of reimbursing the managed care organization for any payments made by the managed care organization to participating providers on behalf of the preferred provider network;

(8) A provision under which the managed care organization is permitted, at the discretion of the managed care organization, to pay participating providers directly and in lieu of the preferred provider network in the event of insolvency or mismanagement by the preferred provider network and that payments made pursuant to this subdivision may be made or reimbursed from the security posted pursuant to subsection (b) of this section;

(9) A provision transferring and assigning contracts between the preferred provider network and participating providers to the managed care organization for the provision of future services by participating providers to enrollees, at the discretion of the managed

care organization, in the event the preferred provider network (A) becomes insolvent, (B) otherwise ceases to conduct business, as determined by the commissioner, or (C) demonstrates a pattern of nonpayment of authorized claims, as determined by the commissioner, for a period in excess of ninety days;

(10) A provision that each contract or agreement between the preferred provider network and participating providers shall include a provision transferring and assigning contracts between the preferred provider network and participating providers to the managed care organization for the provision of future health care services by participating providers to enrollees, at the discretion of the managed care organization, in the event the preferred provider network (A) becomes insolvent, (B) otherwise ceases to conduct business, as determined by the commissioner, or (C) demonstrates a pattern of nonpayment of authorized claims, as determined by the commissioner, for a period in excess of ninety days;

(11) A provision that the preferred provider network shall pay for the delivery of health care services and operate or maintain arrangements or contracts with providers in a manner consistent with the provisions of law that apply to the managed care organization's contracts with enrollees and providers; and

(12) A provision that the preferred provider network shall ensure that utilization review determinations are made in accordance with **[**sections 38a-226 to 38a-226d, inclusive, except that any initial appeal of a determination not to certify an admission, service, procedure or extension of stay shall be made in accordance with subdivision (7) of subsection (a) of section 38a-226c. In cases where an appeal to reverse a determination not to certify is unsuccessful, the preferred provider network shall refer the case to the managed care organization which shall conduct the subsequent appeal, if any, in accordance with said subdivision**]** section 4 of this act.

Sec. 26. Section 38a-479ee of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) If the Insurance Commissioner determines that a preferred provider network or managed care organization, or both, has not complied with any applicable provision of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, the commissioner may (1) order the preferred provider network or managed care organization, or both if both have not complied, to cease and desist all operations in violation of this part or said sections; (2) terminate or suspend the preferred provider network's license; (3) institute a corrective action against the preferred provider network or managed care organization, or both if both have not complied; (4) order the payment of a civil penalty by the preferred provider network or managed care organization, or both if both have not complied, of not more than one thousand dollars for each and every act or violation; (5) order the payment of such reasonable expenses as may be necessary to compensate the commissioner in conjunction with any proceedings held to investigate or enforce violations of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act; and (6) use any of the commissioner's other enforcement powers to obtain compliance with this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act. The commissioner may hold a hearing concerning any matter governed by this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, in accordance with section 38a-16. Subject to the same confidentiality and liability protections set forth in subsections (c) and (k) of section 38a-14, the commissioner may engage the services of attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists to assist the commissioner in conducting an investigation under this section, the cost of which shall be borne by the managed care organization or preferred provider network, or both, that is the subject of the investigation.

(b) If a preferred provider network fails to comply with any

applicable provision of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, the commissioner may assign or require the preferred provider network to assign its rights and obligations under any contract with participating providers in order to ensure that covered benefits are provided.

(c) The commissioner shall receive and investigate (1) any grievance filed against a preferred provider network or managed care organization, or both, by an enrollee or an enrollee's designee concerning matters governed by this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, or (2) any referral from the Office of the Healthcare Advocate pursuant to section 38a-1041, as amended by this act. The commissioner shall code, track and review such grievances and referrals. The preferred provider network or managed care organization, or both, shall provide the commissioner with all information necessary for the commissioner to investigate such grievances and referrals. The information collected by the commissioner pursuant to this section shall be maintained as confidential and shall not be disclosed to any person except (A) to the extent necessary to carry out the purposes of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, (B) as allowed under this title, (C) to the Healthcare Advocate, and (D) information concerning the nature of any grievance or referral and the commissioner's final determination shall be a public record, as defined in section 1-200, provided no personal information, as defined in section 38a-975, shall be disclosed. The commissioner shall report to the Healthcare Advocate on the resolution of any matter referred to the commissioner by the Healthcare Advocate.

Sec. 27. Section 38a-479ff of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

No health insurer, health care center, utilization review company, as

defined in section **[**38a-226**]** 1 of this act, or preferred provider network, as defined in section 38a-479aa, as amended by this act, shall take or threaten to take any adverse personnel or coverage-related action against any enrollee, provider or employee in retaliation for such enrollee, provider or employee (1) filing a complaint with the Insurance Commissioner or the Office of the Healthcare Advocate, or (2) disclosing information to the Insurance Commissioner concerning any violation of this part **[**, sections 38a-226 to 38a-226d, inclusive,**]** or sections 38a-815 to 38a-819, inclusive, as amended by this act, unless such disclosure violates the provisions of chapter 705 or the privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996, **[**(P.L. 104-191) (HIPAA)**]** P.L. 104-191, as amended from time to time, or regulations adopted thereunder. Any enrollee, provider or employee who is aggrieved by a violation of this section may bring a civil action in the Superior Court to recover damages and attorneys' fees and costs.

Sec. 28. Section 38a-483c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Each individual health insurance policy delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2000, shall define the extent to which it provides coverage for experimental treatments.

(b) No such health insurance policy may deny a procedure, treatment or the use of any drug as experimental if such procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration.

(c) Any person who has been diagnosed with a condition that creates a life expectancy in that person of less than two years and who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is experimental may request an expedited appeal as provided in section **[**38a-226c**]** 5 of this act and may appeal a denial

thereof to the Insurance Commissioner in accordance with the procedures established in section **[**38a-478n**]** 7 of this act.

[(d) For the purposes of conducting an appeal pursuant to section 38a-478n on the grounds that an otherwise covered procedure, treatment or drug is experimental, the basis of such an appeal shall be the medical efficacy of such procedure, treatment or drug. The entity conducting the review may consider whether the procedure, treatment or drug (1) has been approved by the National Institute of Health or the American Medical Association, (2) is listed in the United States Pharmacopoeia Drug Information Guide for Health Care Professionals (USP-DI), the American Medical Association Drug Evaluations (AMA-DE), or the American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI), or (3) is currently in a phase III clinical trial of the federal Food and Drug Administration.**]**

Sec. 29. Section 38a-513b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(a) Each group health insurance policy delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2000, shall define the extent to which it provides coverage for experimental treatments.

(b) No such health insurance policy may deny a procedure, treatment or the use of any drug as experimental if such procedure, treatment or drug, for the illness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration.

(c) Any person who has been diagnosed with a condition that creates a life expectancy in that person of less than two years and who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is experimental may request an expedited appeal as provided in section **[**38a-226c**]** 5 of this act and may appeal a denial thereof to the Insurance Commissioner in accordance with the

procedures established in section **[**38a-478n**]** 7 of this act.

[(d) For the purposes of conducting an appeal pursuant to section 38a-478n on the grounds that an otherwise covered procedure, treatment or drug is experimental, the basis of such an appeal shall be the medical efficacy of such procedure, treatment or drug. The entity conducting the review may consider whether the procedure, treatment or drug (1) has been approved by the National Institute of Health or the American Medical Association, (2) is listed in the United States Pharmacopoeia Drug Information Guide for Health Care Professionals (USP-DI), the American Medical Association Drug Evaluations (AMA-DE), or the American Society of Hospital Pharmacists' American Hospital Formulary Service Drug Information (AHFS-DI), or (3) is currently in a phase III clinical trial of the federal Food and Drug Administration.**]**

Sec. 30. Subsection (c) of section 38a-504f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) The insured, or the provider with the insured's written consent, may appeal any denial of coverage for medical necessity to an external, independent review pursuant to section **[**38a-478n**]** 7 of this act. Such external review shall be conducted by a properly qualified review agent whom the department has determined does not have a conflict of interest regarding the cancer clinical trial.

Sec. 31. Subsection (c) of section 38a-542f of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(c) The insured, or the provider with the insured's written consent, may appeal any denial of coverage for medical necessity to an external, independent review pursuant to section **[**38a-478n**]** 7 of this act. Such external review shall be conducted by a properly qualified review agent whom the department has determined does not have a conflict of interest regarding the cancer clinical trial.

Sec. 32. Subdivision (22) of section 38a-816 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(22) Any violation of **[**section 38a-478m**]** sections 4 to 6, inclusive, of this act.

Sec. 33. Subdivision (3) of section 38a-1040 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(3) "Managed care plan" means a product offered by a managed care organization that provides for the financing or delivery of health care services to persons enrolled in the plan through: (A) Arrangements with selected providers to furnish health care services; (B) explicit standards for the selection of participating providers; (C) financial incentives for enrollees to use the participating providers and procedures provided for by the plan; or (D) arrangements that share risks with providers, provided the organization offering a plan described under subparagraph (A), (B), (C) or (D) of this subdivision is licensed by the Insurance Department pursuant to chapter 698, 698a or 700 and that the plan includes utilization review, **[**pursuant to sections 38a-226 to 38a-226d, inclusive**]** as defined in section 1 of this act.

Sec. 34. Subsections (b) and (c) of section 38a-1041 of the general statutes are repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(b) The Office of the Healthcare Advocate may:

(1) Assist health insurance consumers with managed care plan selection by providing information, referral and assistance to individuals about means of obtaining health insurance coverage and services;

(2) Assist health insurance consumers to understand their rights and responsibilities under managed care plans;

(3) Provide information to the public, agencies, legislators and others regarding problems and concerns of health insurance consumers and make recommendations for resolving those problems and concerns;

(4) Assist consumers with the filing of complaints and appeals, including filing appeals with a managed care organization's internal appeal or grievance process and the external appeal process established under **[**section 38a-478n**]** sections 4 to 7, inclusive, of this act;

(5) Analyze and monitor the development and implementation of federal, state and local laws, regulations and policies relating to health insurance consumers and recommend changes it deems necessary;

(6) Facilitate public comment on laws, regulations and policies, including policies and actions of health insurers;

(7) Ensure that health insurance consumers have timely access to the services provided by the office;

(8) Review the health insurance records of a consumer who has provided written consent for such review;

(9) Create and make available to employers a notice, suitable for posting in the workplace, concerning the services that the Healthcare Advocate provides;

(10) Establish a toll-free number, or any other free calling option, to allow customer access to the services provided by the Healthcare Advocate;

(11) Pursue administrative remedies on behalf of and with the consent of any health insurance consumers;

(12) Adopt regulations, pursuant to chapter 54, to carry out the provisions of sections 38a-1040 to 38a-1050, inclusive, as amended by this act; and

(13) Take any other actions necessary to fulfill the purposes of sections 38a-1040 to 38a-1050, inclusive, as amended by this act.

(c) The Office of the Healthcare Advocate shall make a referral to the Insurance Commissioner if the Healthcare Advocate finds that a preferred provider network may have engaged in a pattern or practice that may be in violation of sections **[**38a-226 to 38a-226d, inclusive,**]** 38a-479aa to 38a-479gg, inclusive, as amended by this act, or 38a-815 to 38a-819, inclusive, as amended by this act.

Sec. 35. (*Effective July 1, 2011*) Notwithstanding the provisions of sections 38a-183, 38a-481 and 38a-513 of the general statutes, a health carrier, as defined in section 1 of this act, shall certify to the Insurance Commissioner, in a form and manner prescribed by said commissioner, that any forms or endorsements relating to utilization review, the health carrier's internal grievance process, external review or expedited external review that are filed by such health carrier pursuant to section 38a-183, 38a-481 or 38a-513 of the general statutes for use on or after July 1, 2011, are in compliance with sections 1 to 13, inclusive, of this act and the Patient Protection and Affordable Care Act, P.L. 111-148, as amended from time to time, and any regulations adopted thereunder. Upon receipt by said commissioner of such filing and certification, the health carrier may use such forms or endorsements until such time as said commissioner, after notice and hearing, disapproves their use. A health carrier may use the certification procedure as set forth in this section until June 30, 2012.

Sec. 36. Sections 38a-226 to 38a-226d, inclusive, 38a-478m, 38a-478n and 38a-478p of the general statutes are repealed. (*Effective July 1, 2011*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2011*	New section
Sec. 2	*July 1, 2011*	New section
Sec. 3	*July 1, 2011*	New section

Sec. 4	*July 1, 2011*	New section
Sec. 5	*July 1, 2011*	New section
Sec. 6	*July 1, 2011*	New section
Sec. 7	*July 1, 2011*	New section
Sec. 8	*July 1, 2011*	New section
Sec. 9	*July 1, 2011*	New section
Sec. 10	*July 1, 2011*	New section
Sec. 11	*July 1, 2011*	New section
Sec. 12	*July 1, 2011*	New section
Sec. 13	*July 1, 2011*	New section
Sec. 14	*July 1, 2011*	38a-478
Sec. 15	*July 1, 2011*	38a-19(c)
Sec. 16	*July 1, 2011*	38a-477b(b)
Sec. 17	*July 1, 2011*	38a-478a
Sec. 18	*July 1, 2011*	38a-478b
Sec. 19	*July 1, 2011*	38a-478h
Sec. 20	*July 1, 2011*	38a-478r(d)
Sec. 21	*July 1, 2011*	38a-478s
Sec. 22	*July 1, 2011*	38a-478t
Sec. 23	*July 1, 2011*	38a-478u
Sec. 24	*July 1, 2011*	38a-479aa
Sec. 25	*July 1, 2011*	38a-479bb(d)
Sec. 26	*July 1, 2011*	38a-479ee
Sec. 27	*July 1, 2011*	38a-479ff
Sec. 28	*July 1, 2011*	38a-483c
Sec. 29	*July 1, 2011*	38a-513b
Sec. 30	*July 1, 2011*	38a-504f(c)
Sec. 31	*July 1, 2011*	38a-542f(c)
Sec. 32	*July 1, 2011*	38a-816(22)
Sec. 33	*July 1, 2011*	38a-1040(3)
Sec. 34	*July 1, 2011*	38a-1041(b) and (c)
Sec. 35	*July 1, 2011*	New section
Sec. 36	*July 1, 2011*	Repealer section